STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675908	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avante Rehabilitation Center	225 N Sowers Rd Irving, TX 75061

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain an infection control program designed to prevent the development and transmission of infection for 1 resident (Resident #1) of 2 residents reviewed for infection control. The facility failed to ensure LVN A performed hand hygiene and changed gloves during wound care for Resident #1 on 4/23/2026. This failure could place residents at risk for infection and cross contamination.Record review of Resident #1's Comprehensive MDS assessment, dated 02/24/26, reflected a [AGE] year-old female with an admission date of 02/16/25 with diagnoses that included pressure ulcer of sacral region (triangular bone at the base of the spine), and adult failure to thrive (A condition in older adults characterized by a rapid decline in physical and cognitive function, unintentional weight loss, poor nutrition, and social withdrawal). Resident #1 had a BIMS score of 02 which indicated Resident #1's cognition was severely impaired. Resident#1 required maximum assistance of two-person physical assistance with activities of daily living. In an observation and interview of wound care on Resident #1 by LVN A on 04/23/26 at 11:22 AM, revealed LVN A at the treatment cart. LVN A placed gauze, a calcium alginate dressing (a soft conformable, highly absorbent dressing), and a foam dressing on the bedside table. LVN A and RN B entered the resident's room, they washed their hands and put on gloves and gowns. LVN A uncovered resident, unfastened the brief and turned resident on her side. RN B supported the resident on the side; it revealed the dressing on Resident #1's sacrum. LVN A removed the old dressing and discarded it in the biohazard bag. LVN A then removed her gloves and put on clean gloves without performing hand hygiene and she reached onto the bedside table and pulled vials of normal saline and gauze and cleaned the wound bed. With the same gloves on, she patted the wound bed dry with the gauze. With the same gloves on, she retrieved the calcium alginate dressing and the collagen powder. She covered the wound with collagen and the calcium alginate dressing and covered it with the foam dressing. LVN A then removed her gloves and gown and washed her hands. In an interview with LVN A on 04/23/26 at 11:42 AM, she stated she was supposed to sanitize her hands after each glove change and stated she had failed to do that. She stated she was supposed to change gloves after she cleaned the wound and before she reached out to get the dressing. She stated failing to perform hand hygiene and changing gloves properly created a risk of infection for the resident. In an interview with the DON on 04/23/26 at 11:27 AM, she stated staff were to change their gloves and perform hand hygiene when going from dirty to clean. She stated failing to keep supplies from contamination and failing to perform hand hygiene after glove changes placed residents at risk of infection and cross contamination. Record review of the facility's policy updated December 2025, titled Hand Washing / Hand Hygiene reflected, . This facility considers hand hygiene the primary means to prevent the spread of infections.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE